

Clinical UM Guideline

Subject:	Blepharoplasty, Blepharoptosis Repair, and Brow Lift	Publish Date:	12/29/2021 01/04/2023
Guideline #:	CG-SURG-03	Last Review Date:	11/10/2022+
Status:	Revised		

Description

This document addresses blepharoplasty, blepharoptosis repair, and brow lift procedures. Blepharoplasty is a surgical procedure performed on the upper and/or lower eyelids in which redundant tissues (skin, muscle, or fat) are excised. Blepharoptosis occurs when the eyelid itself droops below its normal position. Brow lift surgery is designed to restore the eyebrow to its normal anatomic position. These procedures may be performed for both cosmetic and functional purposes. The treatment of functional superior visual field restriction generally requires either a blepharoplasty and/or blepharoptosis repair OR a brow lift procedure, depending upon the cause of the visual field loss. Those cases where combined procedures are requested must meet the individual criteria for each procedure.

Note: Conjunctival irritation or eye disease related to ectropion, entropion, metabolic disease, trauma or other conditions may require surgical intervention using a variety of ophthalmologic procedures. These conditions are not discussed in this document. The medical necessity of the surgical correction of these problems should be determined by considering the specific underlying medical and ophthalmologic issues.

Note: For cases where combined procedures (for example, blepharoplasty and brow lift) are requested, the individual must meet the criteria for each procedure.

Note: For information related to the use of the procedures addressed in this document when used for the treatment of individuals with gender dysphoria, please see the following document:

- CG-SURG-27 Gender Affirming Surgery

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

Medically Necessary: In this document, procedures are considered medically necessary if there is a significant functional impairment AND the procedure can be reasonably expected to improve the functional impairment.

Reconstructive: In this document, procedures are considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect.

Note: Not all benefit contracts include benefits for reconstructive services as defined by this document. Benefit language supersedes this document.

Cosmetic: In this document, procedures are considered cosmetic when intended to change a physical appearance that would be considered within normal human anatomic variation. Cosmetic services are often described as those which are primarily intended to preserve or improve appearance.

Clinical Indications

Medically Necessary:

Occlusion Amblyopia (also known as deprivation amblyopia)

Upper eyelid blepharoplasty or blepharoptosis repair is considered **medically necessary to treat occlusion amblyopia** when BOTH of the following criteria are met:

1. Individual is less than or equal to 9 years of age; **and**
2. Intervention is intended to relieve obstruction of central vision which, in the judgment of the treating physician, is severe enough to produce occlusion amblyopia.

Note: *Children older than 9 are not at risk for occlusion amblyopia.

Blepharoplasty or Blepharoptosis Repair Not Related to Visual Field Defects Alone

Upper eyelid blepharoplasty or blepharoptosis repair is considered **medically necessary** for ANY of the following conditions:

1. Difficulty tolerating a prosthesis in an anophthalmic socket; **or**
2. Repair of a functional defect caused by trauma, tumor or surgery; **or**
3. Periorbital sequelae of thyroid disease; **or**

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

4. Nerve palsy.

Note: For cases where combined procedures (for example, blepharoplasty and brow lift) are requested, the individual must meet the criteria for each procedure.

Blepharoplasty for Vision Issues

Unilateral or bilateral **upper eyelid** blepharoplasty is considered **medically necessary** to relieve obstruction of central vision when **ALL** of the following criteria are met:

1. Documented complaints of interference with vision or visual field-related activities causing significant functional impact such as difficulty reading or driving due to upper eyelid skin drooping, looking through the eyelashes or seeing the upper eyelid skin; **and**
 2. There is either redundant skin overhanging the upper eyelid margin and resting on the eyelashes or significant dermatitis on the upper eyelid caused by redundant tissue. This must be confirmed by photographs from the front and side (or sides) on which operation planned with the camera at eye level and the individual looking straight ahead (primary gaze); **and**
 3. Prior to manual elevation of redundant upper eyelid skin (taping), either a or b below are met~~the superior visual field is:~~
 - a. a) The superior visual field is one of the following:
 - i. Less than or equal to 20 degrees; or
 - ii. b) there There is a 30 percent loss of upper field of vision compared to normal; or
 - b. The margin reflex distance between the pupillary light reflex and the upper eyelid skin edge is less than or equal to 2.0 mm;
- and**
4. Manual elevation (taping) of the redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

Blepharoptosis Repair for Vision Issues

Unilateral or bilateral upper eyelid ~~B~~blepharoptosis repair for visual field defects is considered **medically necessary** to relieve obstruction of central vision when **ALL** of the following criteria are met:

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

1. Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to eyelid position; **and**
2. Photographs taken with the camera at eye level and the individual looking straight ahead, with documentation of the abnormal lid position (photos should be submitted for review); **and**
3. Prior to manual elevation of the upper eyelid and redundant upper eyelid skin (taping), either a or b below are met the superior visual field is:
 - a. ~~a)~~ The superior visual field is one of the following:
 - i. Less than or equal to 20 degrees; **or**
 - ii. ~~b)~~ There is a 30 percent loss of upper field of vision compared to normal; **or**
 - or**
 - b. ~~e)~~ The margin reflex distance between the pupillary light reflex and the upper eyelid skin edge is less than or equal to 2.0 mm;
3. **and**
4. Manual elevation (taping) of the upper eyelid and redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

Brow Lift

Brow lift (that is, repair of brow ptosis due to laxity of the forehead muscles) is considered **medically necessary** when **ALL** of the following criteria are met:

1. Brow ptosis is causing a functional impairment of upper/outer visual fields with documented complaints of interference with vision or visual field related activities such as difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin; **and**
2. Photographs show the eyebrow below the supraorbital rim.

Note: ~~Conjunctival irritation or eye disease related to ectropion, entropion, metabolic disease, trauma or other conditions may require surgical intervention using a variety of ophthalmologic procedures. These conditions are not discussed in this document. The medical necessity of the surgical correction of these problems should be determined by considering the specific underlying medical and ophthalmologic issues.~~

Not Medically Necessary:

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

Blepharoplasty, blepharoptosis repair, or brow lift for visual field defects is considered **not medically necessary** when the criteria noted above are not met.

Reconstructive:

Blepharoplasty, blepharoptosis repair or brow lift procedures which are intended to correct a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect are considered reconstructive in nature.

Cosmetic and Not Medically Necessary:

Blepharoplasty, blepharoptosis repair, ~~or~~ and brow lift ~~is~~ are considered **cosmetic and not medically necessary** when the criteria above have not been met, including when performed to improve an individual's appearance in the absence of any signs or symptoms of functional abnormalities.

Lower lid blepharoplasty is considered **cosmetic and not medically necessary**.

~~Reconstructive:~~

~~Blepharoplasty, blepharoptosis repair or brow lift procedures which are intended to correct a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect are considered reconstructive in nature.~~

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

When services may be Medically Necessary or Reconstructive when criteria are met:

CPT

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

00103	Anesthesia for reconstructive procedures of eyelid (eg, blepharoplasty, ptosis surgery)
15822	Blepharoplasty; upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)

ICD-10 Procedure

080N07Z-080PX7Z	Alteration of upper eyelid with autologous tissue substitute [right or left, by approach; includes codes 080N07Z, 080N37Z, 080NX7Z, 080P07Z, 080P37Z, 080PX7Z]
080N0JZ-080PXJZ	Alteration of upper eyelid with synthetic substitute [right or left, by approach; includes codes 080N0JZ, 080N3JZ, 080NXJZ, 080P0JZ, 080P3JZ, 080PXJZ]
080N0KZ-080PXXZ	Alteration of upper eyelid with nonautologous tissue substitute [right or left, by approach; includes codes 080N0KZ, 080N3KZ, 080NXXZ, 080P0KZ, 080P3KZ, 080PXXZ]
080N0ZZ-080PZZ	Alteration of upper eyelid [right or left, by approach; includes codes 080N0ZZ, 080N3ZZ, 080NXXZ, 080P0ZZ, 080P3ZZ, 080PZZ]
08SN0ZZ-08SPXZZ	Reposition upper eyelid [right or left, by approach; includes codes 08SN0ZZ, 08SN3ZZ, 08SNXXZ, 08SP0ZZ, 08SP3ZZ, 08SPXZZ]
0KS10ZZ-0KS14ZZ	Reposition facial muscle [by approach; includes codes 0KS10ZZ, 0KS14ZZ]

ICD-10 Diagnosis

	All diagnoses, including but not limited to the following:
E04.0-E04.9	Other nontoxic goiter

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

E05.00-E05.91	Thyrotoxicosis [hyperthyroidism]
G24.5	Blepharospasm
G51.0-G51.9	Facial nerve disorders
H02.30-H02.36	Blepharochalasis (pseudoptosis)
H02.401-H02.439	Ptosis of eyelid
H02.511-H02.59	Other disorders affecting eyelid function
H02.831-H02.839	Dermatochalasis of eyelid
H02.841-H02.849	Edema of eyelid
H02.851-H02.859	Elephantiasis of eyelid
H02.861-H02.869	Hypertrichosis of eyelid
H02.871-H02.879	Vascular anomalies of eyelid
H02.89	Other specified disorders of eyelid
H53.001-H53.049	Amblyopia ex anopsia
H53.40-H53.489	Visual field defects
H57.811-H57.819	Brow ptosis
Q10.0	Congenital ptosis
Q10.3	Other congenital malformations of eyelid
Q11.1	Other anophthalmos
S05.20XA-S05.32XS	Ocular laceration
S05.40XA-S05.42XS	Penetrating wound of orbit with or without foreign body
S05.8X1A-S05.92XS	Other injuries of eye and orbit; unspecified injury of eye and orbit
T85.79XS	Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, sequela [prosthetic orbital implant]
Z85.22	Personal history of malignant neoplasm of nasal cavities, middle ear, and accessory sinuses
Z85.820-Z85.831	Personal history of malignant neoplasm of skin, bone and soft tissue
Z85.840	Personal history of malignant neoplasm of eye
Z87.720	Personal history of (corrected) congenital malformations of eye
Z90.01	Acquired absence of eye

When services are Not Medically Necessary or Cosmetic and Not Medically Necessary:

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

For the procedure codes listed above when medically necessary or reconstructive criteria are not met, for the following procedure codes for all indications, or when the code describes a procedure designated in the Clinical Indications section as cosmetic and not medically necessary.

CPT

15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid, with extensive herniated fat pad

ICD-10 Procedure

080Q07Z-080RX7Z	Alteration of lower eyelid with autologous tissue substitute [right or left, by approach; includes codes 080Q07Z, 080Q37Z, 080QX7Z, 080R07Z, 080R37Z, 080RX7Z]
080Q0JZ-080RXJZ	Alteration of lower eyelid with synthetic substitute [right or left, by approach; includes codes 080Q0JZ, 080Q3JZ, 080QXJZ, 080R0JZ, 080R3JZ, 080RXJZ]
080Q0KZ-080RXXZ	Alteration of lower eyelid with nonautologous tissue substitute [right or left, by approach; includes codes 080Q0KZ, 080Q3KZ, 080QXKZ, 080R0KZ, 080R3KZ, 080RXXZ]
080Q0ZZ-080RXXZ	Alteration of lower eyelid [right or left, by approach; includes codes 080Q0ZZ, 080Q3ZZ, 080QXZZ, 080R0ZZ, 080R3ZZ, 080RXXZ]
08SQ0ZZ-08SRXZZ	Reposition lower eyelid [right or left, by approach; includes codes 08SQ0ZZ, 08SQ3ZZ, 08SQXZZ, 08SR0ZZ, 08SR3ZZ, 08SRXZZ]

ICD-10 Diagnosis

All diagnoses

Discussion/General Information

Blepharoplasty and repair of blepharoptosis have been accepted as common surgical procedures for the management of upper eyelid conditions. There is adequate evidence in the peer-reviewed medical literature to support the use of upper lid surgery for significantly impaired superior field of vision associated with functional impairment. Such procedures have been shown to improve the individual's field of vision, quality of life, and activities of daily living such as driving and reading.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

Blepharoplasty is performed to remove excess skin tissue from the upper lid. Blepharoptosis repair corrects weakness of the levator palpebrae muscle. This weakness results in the drooping of the upper lid with possible obstruction of the superior visual field if the abnormality is severe enough. Many cases of mild ptosis do not result in significant superior visual field compromise. Aging or (less commonly) disease may result in excess upper lid skin that overhangs the lashes and restricts the superior visual field. Blepharoplasty is most commonly performed for cosmetic reasons, but may be medically necessary if vision is impaired. There are many causes of ptosis and pseudoptosis: congenital disorders; muscle, nervous, and mechanical disorders; complications due to eye surgery; eyelid and brain tumors; and age-related changes that damage the musculature of the eyelid. Many common medical disorders have been associated with ptosis including diabetes, stroke, and myasthenia gravis. If congenital ptosis is untreated in children, amblyopia (lazy eye) may develop. Ptosis repair typically involves reconstructive procedures on the levator muscle and connective tissues of the eyelid.

A brow lift (repair of eyebrow ptosis), when performed to improve an individual's appearance in the absence of any signs and/or symptoms of functional abnormalities, is considered cosmetic. In extreme cases, if a person has significant brow ptosis, a brow lift may be needed for functional reasons. Brow lift surgery works by strengthening the tissues that support the brow. Often this is accomplished with a forehead procedure, which results in a less visible scar than procedures performed on the brow itself. For some individuals, the midforehead is useful as the site of incision when deep forehead lines (furrows) are present to minimize scarring. Brow lifts may be performed as a separate procedure or in conjunction with blepharoplasty or blepharoptosis repair. In some instances, a functional brow lift may be the only procedure required to correct functional superior visual field loss.

Upper eyelid blepharoplasty or blepharoptosis repair may be done for the treatment of occlusion amblyopia, a condition that can develop in children when one eye is occluded by excess eyelid skin or a drooping eyelid. When such conditions are present and one eye is occluded, the brain may start favoring one eye more than the other. Over time, the brain relies more on the favored eye, which becomes stronger and the other eye weaker, leading to poor overall vision. Amblyopia most commonly develops on children under the age of 7 and there are several types. Occlusion amblyopia, also referred to as deprivation amblyopia, as noted above, occurs when one eye is occluded. On addition to occurring in a child due to excess eyelid skin or eyelid ptosis, it more commonly occurs due to eyepatch therapy in a child being treated for strabismus (also known as strabismic amblyopia). Strabismic amblyopia may be treated with vision therapy, eyedrops and/or surgery of the weakened eye muscles. Amblyopia may also result from a difference in visual acuity between the eyes, which is known as refractive amblyopia. Refractive amblyopia is usually treated with corrective lenses.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

Assessment of the degree of visual impairment due to either blepharoptosis or excess upper eyelid skin is critical in understanding the severity of functional impairment due to the condition. Two accepted standard methods for such measurement include visual field assessments and measurement of the margin reflex distance (MRD, also known as the mid-pupil to upper eyelid distance). Both tests evaluate the degree of visual field loss due to the intrusion of either the upper eyelid edge or excess eyelid skin into the visual field (Meyer, 1989; Meyer, 1993). Visual field assessment may be performed manually or via computerized analysis devices to evaluate and map an individual's peripheral field of vision for each eye. Measurement of the MRD is a method that has been validated in research studies to correlate well with the results of visual field tests (Boboridis, 2001; Meyer, 1998; Rebowe, 2020). MRD is calculated by measuring the distance between the corneal light reflex (the central visual axis) and the edge of either the upper eyelid or upper eyelid skin, whichever is closest. An MRD measurement of 1-2 mm is generally considered to be associated with significant visual impairment indicating a good candidate for repair (Rebowe, 2020; Small, 1998).

In 2011, Cahill and colleagues published a report from the American Academy of Ophthalmology (AAO) on the functional indications for upper eyelid surgery. The literature search strategy identified a small number of relevant case series meeting the inclusion criteria (n=13). These studies evaluated a wide variety of surgical approaches to ptosis. One study utilized subjects with "simulated ptosis," created with special contact lenses, while the remaining studies involved subjects with ptosis. The authors discuss additional studies in the discussion section, which were explicitly excluded from the literature search. These studies are included to demonstrate the effect of ptosis on superior peripheral field of vision and are the basis of the visual field loss recommendation. These studies all utilized different perimetric techniques to evaluate visual field loss. The impact of ptosis on down-gaze is addressed in the discussion section as well. The authors address several small studies not included in the initial literature abstraction. These studies demonstrate the effect of visual field impairment and low MRD₁ measurements impact on down-gaze. However, the result of one small study (n=34) demonstrates how ptosis repair impacts down-gaze impairment. The report concludes by providing guidelines for "indicating when surgical intervention is expected to provide functionally significant improvement." However, it must be noted that these recommendations are based on a limited number of poor quality studies with small numbers of participants. The authors note that these studies are only Level III evidence. Additionally, the studies included in the review are primarily regarding the impact of surgical correction of ptosis, rather than on the identification of functional impairment. The data used in this report is limited to case reports, the majority of which have methodological issues, and the body of evidence is insufficient to allow conclusions to be drawn regarding selection criteria for upper eyelid ptosis and blepharoplasty.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

In 2019, Hollander and colleagues conducted a large systematic review on the functional outcomes of upper eyelid blepharoplasty. The researchers reviewed 3525 studies and included 28 in the final review. Outcomes included dry eyes, upper visual field, eyebrow height, shape of cornea, sensitivity of upper eyelid skin, contrast sensitivity, eyelid kinematics and quality of life. The authors concluded that upper blepharoplasty has many beneficial functional outcomes including increased visual field, improvement in headaches and improvement in overall quality of life. The review's design was limited by inclusion of studies with mostly female participants (several 80-100% female), compromising generalizability of the results, and the lack of standardization in surgical techniques chosen for inclusion.

Definitions

Amblyopia: A type of poor vision that is characterized by one eye being stronger than the other. This condition is due to the brain favoring one eye more than the other. Over time the brain relies more on the favored eye, which becomes the stronger eye and the other eye weaker. The cause of amblyopia may be congenital or due to environmental factors and most frequently occurs in children.

Anophthalmia: Absence of all eye tissue; may be present at birth.

Blepharitis: Inflammation of the eyelids.

Blepharoplasty: Surgical procedures on the upper or lower eyelids commonly done for cosmetic reasons or to correct functional problems.

Blepharospasm: Involuntary spasmodic contraction of the orbicularis oculi muscle; may occur in isolation or be associated with other dystonic contractions of facial, jaw, or neck muscles; usually initiated or aggravated by emotion, fatigue, or drugs.

Central vision: Straight-ahead vision, where light and image is focused on the macula and fovea centralis area of the retina, as distinguished from side or peripheral vision; the part of the vision that is essential for driving, reading, and other activities that require detailed, straight-ahead vision.

Dermatochalasis: The presence of redundant eyelid skin, almost always progressive with aging.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

Ectropion: Outward turning or eversion of the eyelid.

Entropion: Inward turning or inversion of the eyelid.

Epiphora: Chronic and excessive tearing.

Occlusion amblyopia (also referred to as deprivation amblyopia): The development of amblyopia in a child who has occlusion of one eye. In most cases, this occurs in previously stronger eye in a child undergoing patch therapy for strabismus, but may also occur in individuals with other types of eye occlusion, such as excess eyelid skin or eyelid ptosis.

Pseudoptosis: A condition mimicking true ptosis; does not require surgical intervention.

Ptosis: Drooping of the upper eyelid; may be caused by levator dysfunction or neurologic diseases.

Trichiasis: A lid deformity resulting in the misdirection of eyelashes toward the eye.

References

Peer Reviewed Publications:

1. Aldave AJ, Maus M, Rubin PA. Advances in the management of lower eyelid retraction. *Facial Plast Surg.* 1999; 15(3):213-224.
2. Biesman BS. Blepharoplasty. *Semin Cutan Med Surg.* 1999; 18(2):129-138.
3. Boboridis K, Assi A, Indar A, et al. Repeatability and reproducibility of upper eyelid measurements. *Br J Ophthalmol.* 2001; 85(1):99-101.
4. Castro E, Foster JA. Upper lid blepharoplasty. *Facial Plast Surg.* 1999; 15(3):173-178.
5. Edmonson BC, Wulc AE. Ptosis evaluation and management. *Otolaryngol Clin North Am.* 2005; 38(5):921-946.
6. Federici TJ, Meyer DR, Lininger LL. Correlation of the vision-related functional impairment associated with blepharoptosis and the impact of blepharoptosis surgery. *Ophthalmology.* 1999; 106(9):1705-1712.
7. Fung S, Malhotra R, Selva D. Thyroid orbitopathy. *Aust Fam Physician.* 2003; 32(8):615-620.
8. Hoenig JA. Comprehensive management of eyebrow and forehead ptosis. *Otolaryngol Clin North Am.* 2005; 38(5):947-984.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

9. Hollander MHJ, Contini M, Pott JW, et al. Functional outcomes of upper eyelid blepharoplasty: A systematic review. *J Plast Reconstr Aesthet Surg*. 2019; 72(2):294-309.
10. Karesh JW. Blepharoplasty: an overview. *Atlas Oral Maxillofac Surg Clin North Am*. 1998; 6(2):87-109.
11. Mellington, F, Khooshabeh, R. Brow ptosis: are we measuring the right thing? The impact of surgery and the correlation of objective and subjective measures with postoperative improvement in quality-of-life. *Eye (Lond)*. 2012; 26(7):997-1003.
12. Meyer DR, Linberg JV, Powell SR, Odom JV. Quantitating the superior visual field loss associated with ptosis. *Arch Ophthalmol*. 1989; 107(6):840-843.
13. Meyer DR, Stern JH, Jarvis JM, Lininger LL. Evaluating the visual field effects of blepharoptosis using automated static perimetry. *Ophthalmology*. 1993; 100(5):651-658.
14. Mullins JB, Holds JB, Branham GH, Thomas JR. Complications of the transconjunctival approach: a review of 400 cases. *Arch Otolaryngol Head Neck Surg*. 1997; 123(4):385-388.
15. Patel BC. Surgical management of essential blepharospasm. *Otolaryngol Clin North Am*. 2005; 38(5):1075-1098.
16. Rizk SS, Matarasso A. Lower lid blepharoplasty: analysis of indications and the treatment of 100 patients. *Plast Reconstr Surg*. 2003; 111(3):1299-1306.
17. Sabiston DC Jr. *Textbook of Surgery: The Biological Basis of Modern Surgical Practice*. 15th ed., (Philadelphia: W.B. Saunders, Co., 1997), PP. 1326 & 1327.
18. Sakol PJ, Mannor G, Massaro BM. Congenital and acquired blepharoptosis. *Curr Opin Ophthalmol*. 1999; 10(5):335-339.
19. Small RG, Meyer DR. Eyelid metrics. *Ophthalm Plast Reconstr Surg*. 2004; 20(4):266-267.
20. Small RG, Sabates NR, Burrows D. The measurement and definition of ptosis. *Ophthalm Plast Reconstr Surg*. 1989; 5(3):171-175.
21. Weissman, J, Most, S. Upper lid blepharoplasty. *Facial Plastic Surg*. 2013; 29(01):16-21.

Government Agency, Medical Society, and Other Authoritative Publications:

1. Cahill KV, Bradley EA, Meyer DR, et al. Functional indications for upper eyelid ptosis and blepharoplasty surgery: a report by the American Academy of Ophthalmology. *Ophthalmology*. 2011; 118(12):2510-2517.
- +2. Kim KK, Granick MS, Baum GA, et al. American Society of Plastic Surgeons evidence-based clinical practice guideline: eyelid surgery for upper visual field improvement. *Plast Reconstr Surg*. 2022; 150(2):419e-434e.

Index

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

Blepharoplasty
Blepharoptosis Repair
Brow Lift
Ptosis Repair

History

Status	Date	Action
<u>Revised</u>	<u>11/1/2022</u>	<u>Medical Policy & Technology Assessment Committee (MPTAC) review. Moved notes re: conjunctival irritation etc. and combined procedures to the Description section. Reorganized the order of the Clinical Indications section. Reformatted section headers. Revised the occlusion amblyopia MN statement. Added “for visual field defects” to both the blepharoplasty and blepharoptosis repair MN statements. Revised hierarchy for the MN criteria re: pre-taping impairment. Added “unilateral or bilateral upper eyelid” to the blepharoptosis repair MN statement. Revised and NMN statement to address when criteria have not been met. Updated Description, Definitions and References sections. Updated Coding section to remove code 00103 for associated anesthesia.</u>
Reviewed	11/11/2021	Medical Policy & Technology Assessment Committee (MPTAC) review. Minor Formatting update in MN section. Description and References sections updated.
	04/07/2021	Revised MN definition text in the Description section.
Reviewed	11/05/2020	MPTAC review. Discussion/General Information and References sections updated. Reformatted Coding section; updated with additional diagnosis code examples.
Reviewed	11/07/2019	MPTAC review. Discussion/General Information and References sections updated.
Reviewed	01/24/2019	MPTAC review. References section updated.
	09/20/2018	Updated Coding section with 10/01/2018 ICD-10-CM diagnosis code changes; added H57.811-H57.819.
Revised	02/27/2018	MPTAC review. The document header wording updated from “Current Effective Date” to “Publish Date.” Clarified criterion for blepharoptosis regarding

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

		documentation with photographs. Updated Discussion/General Information and References sections.
Revised	02/02/2017	MPTAC review. Clarified blepharoplasty criteria regarding interference with vision or visual field-related activities. Updated Definitions and References.
	10/01/2016	Updated Coding section with 10/01/2016 ICD-10-CM diagnosis code changes.
Revised	02/04/2016	MPTAC review. Defined abbreviation in the brow lifts medically necessary statement. Updated References. Removed ICD-9 codes from Coding section.
Reviewed	02/05/2015	MPTAC review. Updated Discussion and Reference sections.
Reviewed	02/13/2014	MPTAC review. Updated Reference section.
Revised	02/14/2013	MPTAC review. Revised the medically necessary criteria for blepharoplasty and blepharoptosis repair to clarify visual field criteria. Updated Reference section.
Reviewed	05/10/2012	MPTAC review. Updated Coding, Discussion and Reference sections.
Reviewed	05/19/2011	MPTAC review.
Reviewed	05/13/2010	MPTAC review.
Revised	05/21/2009	MPTAC review. Clarified criteria language in the medically necessary section for Blepharoptosis Repair.
Revised	11/20/2008	MPTAC review. Deleted age-related criteria in Blepharoplasty and Blepharoptosis sections. Made medically necessary criteria for visual fields for blepharoplasty and blepharoptosis optional instead of mandatory. Added Margin Reflex Distance (MRD) as optional for the medically necessary sections of blepharoplasty and blepharoptosis. Updated Reference section.
Revised	02/21/2008	MPTAC review. Clarified that visual fields must be submitted. Added reconstructive statement and definitions. Clarified that nerve palsy is a separate indication. Added note after Reconstructive definition to clarify that not all benefit contracts include a reconstructive services benefit. References updated. The phrase “cosmetic” was clarified to read “cosmetic and not medically necessary.” This change was approved at the November 29, 2007 MPTAC meeting.
Revised	03/08/2007	MPTAC review. Medically necessary criteria for blepharoplasty, blepharoptosis and brow lift clarified. General Information section updated.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

Revised	09/14/2006	MPTAC review. Clarified visual fields criteria for adults. Added language addressing blepharoplasty in children. Added lower lid blepharoplasty as cosmetic. Coding updated.
Revised	03/23/2006	MPTAC review. Revision to clarify the vision field criteria.
Revised	07/14/2005	MPTAC review. Revision based on Pre-merger Anthem and Pre-merger WellPoint Harmonization.

Pre-Merger Organizations	Last Review Date	Document Number	Title
Anthem, Inc.	07/28/2004	SURG.00012	Blepharoplasty
WellPoint Health Networks, Inc.	04/28/2005	Clinical Guideline	Blepharoplasty and Ptois

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.